

**VANCOMYCIN HYDROCHLORIDE - vancomycin hydrochloride injection, powder, lyophilized, for solution**  
GeneraMedix Inc.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of vancomycin and other antibacterial drugs, vancomycin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

**DESCRIPTION**

Sterile Vancomycin Hydrochloride, USP is a white-to-off white lyophilized powder, for preparing intravenous (IV) infusions. Each vial contains the equivalent of 500 mg or 1 g vancomycin base; 500 mg of the base is equivalent to 0.34 mmol. When reconstituted with Sterile Water for Injection to a concentration of 50 mg/mL, a clear solution is obtained with a pH between 2.5 and 4.5. Sterile Vancomycin Hydrochloride, USP should be administered intravenously in diluted solution (see DOSAGE AND ADMINISTRATION). **AFTER RECONSTITUTION, FURTHER DILUTION IS REQUIRED BEFORE USE.**

Vancomycin is a tricyclic glycopeptide antibiotic derived from *Amycolatopsis orientalis* (formerly *Nocardia orientalis*). The molecular formula is  $C_{66}H_{75}Cl_{12}N_9O_{24} \cdot HCl$  and the molecular weight is 1,485.71. Vancomycin hydrochloride has the following structural formula:



**CLINICAL PHARMACOLOGY**

In subjects with normal kidney function, multiple intravenous dosing of 1 g of vancomycin (15 mg/kg) infused over 60 minutes produces mean plasma concentrations of approximately 63 mcg/mL immediately after the completion of infusion, mean plasma concentrations of approximately 23 mcg/mL 2 hours after infusion, and mean plasma concentrations of approximately 8 mcg/mL 11 hours after the end of the infusion. Multiple dosing of 500 mg infused over 30 minutes produces mean plasma concentrations of about 49 mcg/mL at the completion of infusion, mean plasma concentrations of about 19 mcg/mL two hours after infusion, and mean plasma concentrations of about 10 mcg/mL six hours after infusion. The plasma concentrations during multiple dosing are similar to those after a single dose.

The mean elimination half-life of vancomycin from plasma is 4 to 6 hours in subjects with normal renal function. In the first 24 hours, about 75% of an administered dose of vancomycin is excreted in urine by glomerular filtration. Mean plasma clearance is about 0.058 L/kg/h, and mean renal clearance is about 0.048 L/kg/h. Renal dysfunction slows excretion of vancomycin. In anephric patients, the average half-life of elimination is 7.5 days. The distribution coefficient is from 0.3 to 0.43 L/kg. There is no apparent metabolism of the drug. About 60% of an intraperitoneal dose of vancomycin administered during peritoneal dialysis is absorbed systemically in 6 hours. Serum concentrations of about 10 mcg/mL are achieved by intraperitoneal injection of 30 mg/kg of vancomycin. However, the safety and efficacy of the intraperitoneal use of vancomycin has not been established in adequate and well-controlled trials (see PRECAUTIONS).

Total systemic and renal clearance of vancomycin may be reduced in the elderly.

Vancomycin is approximately 55% serum protein bound as measured by ultrafiltration at vancomycin serum concentrations of 10 to 100 mcg/mL. After IV administration of vancomycin, inhibitory concentrations are present in pleural, pericardial, ascitic, and synovial fluids; in urine; in peritoneal dialysis fluid; and in atrial appendage tissue. Vancomycin does not readily diffuse across normal meninges into the spinal fluid; but, when the meninges are inflamed, penetration into the spinal fluid occurs.

**Microbiology**

The bactericidal action of vancomycin results primarily from inhibition of cell-wall biosynthesis. In addition, vancomycin alters bacterial-cell-membrane permeability and RNA synthesis. There is no cross-resistance between vancomycin and other antibiotics. Vancomycin is not active *in vitro* against gram-negative bacilli, mycobacteria, or fungi.

**Synergy**

The combination of vancomycin and an aminoglycoside acts synergistically *in vitro* against many strains of *Staphylococcus aureus*, *Streptococcus bovis*, enterococci, and the viridans group streptococci.

Vancomycin has been shown to be active against most strains of the following microorganisms, both *in vitro* and in clinical infections as described in the INDICATIONS AND USAGE section.

**Aerobic gram-positive microorganism**

Diphtheroids

Enterococci (e.g., *Enterococcus faecalis*)

Staphylococci, including *Staphylococcus aureus* and *Staphylococcus epidermidis* (including heterogeneous methicillin-resistant strains)

*Streptococcus bovis*

Viridans group streptococci

The following *in vitro* data are available, **but their clinical significance is unknown.**

Vancomycin exhibits *in vitro* MIC's of 1 mcg/mL or less against most ( $\geq 90\%$ ) strains of streptococci listed below and MIC's of 4 mcg/mL or less against most ( $\geq 90\%$ ) strains of other listed microorganisms; however, the safety and effectiveness of vancomycin in treating clinical infections due to these microorganisms have not been established in adequate and well-controlled clinical trials.

#### Aerobic gram-positive microorganisms

*Listeria monocytogenes*

*Streptococcus pyogenes*

*Streptococcus pneumoniae* (including penicillin-resistant strains)

*Streptococcus agalactiae*

#### Anaerobic gram-positive microorganisms

*Actinomyces species*

*Lactobacillus species*

#### Susceptibility Tests Methods

When available, the clinical microbiology laboratory should provide the results of *in vitro* susceptibility test results for antimicrobial drugs used in local hospitals and practice areas to the physician as periodic reports that describe the susceptibility profile of nosocomial and community-acquired pathogens. These reports should aid the physician in selecting the most effective antimicrobial.

#### Dilution Techniques

Quantitative methods are used to determine antimicrobial minimum inhibitory concentrations (MICs). These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. The MICs should be determined using a standardized procedure.

Standardized procedures are based on a dilution method<sup>1,2</sup> (broth, agar or microdilution) or equivalent using standardized inoculum concentrations and concentrations of vancomycin powder. The MIC values should be interpreted according to the criteria in Table 1.

#### Diffusion Techniques

Quantitative methods that require measurement of zone diameters also provide reproducible estimates of the susceptibility of bacteria to antimicrobial compounds. One such standardized procedure<sup>2,3</sup> requires the use of standardized inoculum concentrations. This procedure uses paper disks impregnated with 30 mcg of vancomycin to test the susceptibility of microorganisms to vancomycin. Interpretation involves correlation of the diameter obtained in the disk test with the MIC for vancomycin. Reports from the laboratory providing results of the standard single-disk susceptibility test with a 30 mcg vancomycin disk should be interpreted according to the following criteria in Table 1.

Table 1: Susceptibility Test Interpretive Criteria for Vancomycin						
Pathogen	Minimum Inhibitory Concentrations (mcg/mL)			Disk Diffusion Diameters (mm)		
	Susceptible (S)	Intermediate (I)	Resistant (R)	Susceptible (S)	Intermediate (I)	Resistant (R)
<i>Enterococci</i> <sup>a</sup>	$\leq 4$	8-16	$\geq 32$	$\geq 17^b$	15-16 <sup>b</sup>	$\leq 14^b$
<i>Staphylococcus aureus</i>	$\leq 2$	4-8	$\geq 16$	$\geq 15^c$	-	-
Coagulase-negative staphylococci	$\leq 4$	8-16	$\geq 32$	$\geq 15^c$	-	-
Streptococci other than <i>S. pneumoniae</i>	$\leq 1^{c,d}$	-	-	$\geq 17^{c,e}$	-	-

<sup>a</sup> A  $\beta$ -lactamase test using an inoculum  $\geq 10^7$  CFU/mL or direct colony growth and nitrocefin-based substrate should be performed to detect either ampicillin or penicillin resistance due to  $\beta$ -lactamase production.

<sup>b</sup> Plates should be held for full 24 hours and examined using transmitted light. The presence of haze or any growth within the zone of inhibition indicates resistance. Those enterococci with intermediate zones of inhibition should be tested by standardized procedure based on dilution method<sup>1,2</sup> (broth or agar) or equivalent.

<sup>c</sup> The current absence of resistant isolates precludes defining results other than "Susceptible". Isolates yielding results suggestive of "Nonsusceptible" should be submitted to reference laboratory for further testing.

<sup>d</sup> Interpretative criteria applicable only to tests performed by broth microdilution method using cation-adjusted Mueller-Hinton broth with 2 to 5% lysed horse blood<sup>1,2</sup>.

<sup>e</sup> Interpretative criteria applicable only to tests performed by disk diffusion method using Mueller-Hinton agar with 5% defibrinated sheep blood and incubated in 5% CO<sub>2</sub><sup>3</sup>.

A report of “Susceptible” indicates that the pathogen is likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable. A report of “Intermediate” indicates that the result should be considered equivocal, and, if the microorganism is not fully susceptible to alternative, clinically feasible drugs, the test should be repeated. This category implies possible clinical applicability in body sites where the drug is physiologically concentrated or in situations where high dosage of drug can be used. This category also provides a buffer zone which prevents small uncontrolled technical factors from causing major discrepancies in interpretation. A report of “Resistant” indicates that the pathogen is not likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable; other therapy should be selected.

### Quality Control

Standardized susceptibility test procedures require the use of laboratory control microorganisms to monitor and ensure the accuracy and precision of the supplies and reagents used in the assay, and the techniques of the individuals performing the test. Standard vancomycin powder should provide MIC values provided below. For the diffusion technique, the 30 mcg vancomycin disk should provide the following zone diameters with the quality control strains:

Table 2. <i>In Vitro</i> Susceptibility Test Quality Control Ranges for Vancomycin		
Organism (ATTC #)	MIC range (mcg/mL)	Disk diffusion range (mm)
<i>Enterococcus faecalis</i> (29212)	1-4	Not applicable
<i>Staphylococcus aureus</i> (29213)	0.5-2	Not applicable
<i>Staphylococcus aureus</i> (25923)	Not applicable	17 - 21
<i>Streptococcus pneumoniae</i> (49619) <sup>a</sup>	0.12-0.5	20 – 27
<sup>a</sup> Interpretative criteria applicable only to tests performed using cation-adjusted Mueller-Hinton broth with 2 to 5% lysed horse blood <sup>1</sup> . Disk diffusion interpretative criteria applicable only to tests performed using Mueller- Hinton agar with 5% defibrinated sheep blood and incubated in 5% CO <sub>2</sub> <sup>2</sup> .		

### INDICATION USAGE

Vancomycin is indicated for the treatment of serious or severe infections caused by susceptible strains of methicillin-resistant (beta-lactam-resistant) staphylococci. It is indicated for penicillin-allergic patients, for patients who cannot receive or who have failed to respond to other drugs, including the penicillins or cephalosporins, and for infections caused by vancomycin-susceptible organisms that are resistant to other antimicrobial drugs. Vancomycin is indicated for initial therapy when methicillin-resistant staphylococci are suspected, but after susceptibility data are available, therapy should be adjusted accordingly.

Vancomycin is effective in the treatment of staphylococcal endocarditis. Its effectiveness has been documented in other infections due to staphylococci, including septicemia, bone infections, lower respiratory tract infections, skin and skin structure infections. When staphylococcal infections are localized and purulent, antibiotics are used as adjuncts to appropriate surgical measures.

Vancomycin has been reported to be effective alone or in combination with an aminoglycoside for endocarditis caused by *Streptococcus viridans* or *S. bovis*. For endocarditis caused by enterococci (e.g., *E. faecalis*), vancomycin has been reported to be effective only in combination with an aminoglycoside.

Vancomycin has been reported to be effective for the treatment of diphtheroid endocarditis. Vancomycin has been used successfully in combination with either rifampin, an aminoglycoside, or both in early-onset prosthetic valve endocarditis caused by *S. epidermidis* or diphtheroids.

Specimens for bacteriologic cultures should be obtained in order to isolate and identify causative organisms and to determine their susceptibilities to vancomycin.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of vancomycin and other antibacterial drugs, vancomycin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

### CONTRAINDICATIONS

Vancomycin is contraindicated in patients with known hypersensitivity to this antibiotic. Diluents containing dextrose may be contraindicated in patients with known allergy to corn or corn products.

### WARNINGS

Rapid bolus administration (e.g., over several minutes) may be associated with exaggerated hypotension, including shock, and, rarely, cardiac arrest. Vancomycin should be administered over a period of not less than 60 minutes to avoid rapid-infusion-related reactions. Stopping the infusion usually results in prompt cessation of these reactions.

Ototoxicity has occurred in patients receiving vancomycin. It may be transient or permanent. It has been reported mostly in patients who have been given excessive doses, who have an underlying hearing loss, or who are receiving concomitant therapy with another ototoxic agent, such as an aminoglycoside. Vancomycin should be used with caution in patients with renal insufficiency because the risk of toxicity is appreciably increased by high, prolonged blood concentrations.

Dosage of vancomycin must be adjusted for patients with renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

*Clostridium difficile* associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including sterile vancomycin hydrochloride, USP, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of *C. difficile*.

*C. difficile* produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of *C. difficile* cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents.

If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibiotic treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

## **PRECAUTIONS**

### **General**

Prolonged use of vancomycin may result in the overgrowth of nonsusceptible microorganisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken. In rare instances, there have been reports of pseudomembranous colitis due to *C. difficile* developing in patients who received intravenous vancomycin.

In order to minimize the risk of nephrotoxicity when treating patients with underlying renal dysfunction or patients receiving concomitant therapy with an aminoglycoside, serial monitoring of renal function should be performed and particular care should be taken in following appropriate dosing schedules (see DOSAGE AND ADMINISTRATION).

Serial tests of auditory function may be helpful in order to minimize the risk of ototoxicity.

Reversible neutropenia has been reported in patients receiving vancomycin (see ADVERSE REACTIONS). Patients who will undergo prolonged therapy with vancomycin or those who are receiving concomitant drugs that may cause neutropenia should have periodic monitoring of the leukocyte count.

Vancomycin is irritating to tissue and must be given by a secure intravenous route of administration. Pain, tenderness, and necrosis occur with inadvertent extravasation. Thrombophlebitis may occur, the frequency and severity of which can be minimized by slow infusion of the drug and by rotation of venous access sites.

There have been reports that the frequency of infusion-related events (including hypotension, flushing, erythema, urticaria, and pruritus) increases with the concomitant administration of anesthetic agents. Infusion-related events may be minimized by the administration of vancomycin as a 60-minute infusion prior to anesthetic induction. The safety and efficacy of vancomycin administered by the intrathecal (intralumbar or intraventricular) route or by the intraperitoneal route have not been established by adequate and well-controlled trials.

Reports have revealed that administration of sterile vancomycin by the intraperitoneal route during continuous ambulatory peritoneal dialysis (CAPD) has resulted in a syndrome of chemical peritonitis. To date, this syndrome has ranged from a cloudy dialysate alone to a cloudy dialysate accompanied by variable degrees of abdominal pain and fever. This syndrome appears to be short-lived after discontinuation of intraperitoneal vancomycin.

Prescribing vancomycin in the absence of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

### **Drug Interactions**

Concomitant administration of vancomycin and anesthetic agents has been associated with erythema and histamine-like flushing (see PRECAUTIONS, Pediatrics Use) and anaphylactoid reactions (see ADVERSE REACTIONS).

Concurrent and/or sequential systemic or topical use of other potentially neurotoxic and/or nephrotoxic drugs, such as amphotericin B, aminoglycosides, bacitracin, polymyxin B, colistin, viomycin, or cisplatin, when indicated, requires careful monitoring.

### **Pregnancy**

#### **Teratogenic Effects**

#### **Pregnancy Category C**

Animal reproduction studies have not been conducted with vancomycin. It is not known whether vancomycin can affect reproduction capacity. In a controlled clinical study, the potential ototoxic and nephrotoxic effects of vancomycin on infants were evaluated when the drug was administered to pregnant women for serious staphylococcal infections complicating intravenous drug abuse. Vancomycin was found in cord blood. No sensorineural hearing loss or nephrotoxicity attributable to vancomycin was noted. One infant whose mother received vancomycin in the third trimester experienced conductive hearing loss that was not attributed to the administration of vancomycin. Because the number of patients treated in this study was limited and vancomycin was administered only in the second and third trimesters, it is not known whether vancomycin causes fetal harm. Vancomycin should be given to a pregnant woman only if clearly needed.

## **Nursing Mothers**

Vancomycin is excreted in human milk. Caution should be exercised when vancomycin is administered to a nursing woman. Because of the potential for adverse events, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

## **Pediatric Use**

In pediatric patients, it may be appropriate to confirm desired vancomycin serum concentrations. Concomitant administration of vancomycin and anesthetic agents has been associated with erythema and histamine-like flushing in pediatric patients (see ADVERSE REACTIONS). The potential for toxic effects in pediatric patients from chemicals that may leach from the plastic containers into the single-dose, premixed intravenous preparation has not been determined.

## **Geriatric Use**

The natural decrement of glomerular filtration with increasing age may lead to elevated vancomycin serum concentrations if dosage is not adjusted. Vancomycin dosage schedules should be adjusted in elderly patients (see DOSAGE AND ADMINISTRATION).

## **Information for Patients**

Patients should be counseled that antibacterial drugs including vancomycin, should only be used to treat bacterial infections. They do not treat viral infections (e.g., the common cold). When vancomycin is prescribed to treat a bacterial infection, patients should be told that although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by vancomycin or other antibacterial drugs in the future. Diarrhea is a common problem caused by antibiotics which usually ends when the antibiotic is discontinued. Sometimes after starting treatment with antibiotics, patients can develop watery and bloody stools (with or without stomach cramps and fever) even as late as two or more months after having taken the last dose of the antibiotic. If this occurs, patients should contact their physician as soon as possible.

## **ADVERSE REACTIONS**

### **Infusion-Related Events**

During or soon after rapid infusion of vancomycin, patients may develop anaphylactoid reactions, including hypotension (see ANIMAL PHARMACOLOGY), wheezing, dyspnea, urticaria, or pruritus. Rapid infusion may also cause flushing of the upper body ("red neck") or pain and muscle spasm of the chest and back. These reactions usually resolve within 20 minutes but may persist for several hours. Such events are infrequent if vancomycin is given by a slow infusion over 60 minutes. In studies of normal volunteers, infusion-related events did not occur when vancomycin was administered at a rate of 10 mg/min or less.

### **Nephrotoxicity**

Renal failure, principally manifested by increased serum creatinine or BUN concentrations, especially in patients administered large doses of vancomycin, has been reported rarely. Cases of interstitial nephritis have also been reported rarely. Most of these have occurred in patients who were given aminoglycosides concomitantly or who had preexisting kidney dysfunction. When vancomycin was discontinued, azotemia resolved in most patients.

### **Gastrointestinal**

Onset of pseudomembranous colitis symptoms may occur during or after antibiotic treatment (see WARNINGS).

### **Ototoxicity**

A few dozen cases of hearing loss associated with vancomycin have been reported. Most of these patients had kidney dysfunction or a preexisting hearing loss or were receiving concomitant treatment with an ototoxic drug. Vertigo, dizziness, and tinnitus have been reported rarely.

### **Hematopoietic**

Reversible neutropenia, usually starting 1 week or more after onset of therapy with vancomycin or after a total dosage of more than 25 g, has been reported for several dozen patients. Neutropenia appears to be promptly reversible when vancomycin is discontinued. Thrombocytopenia has rarely been reported. Although a causal relationship has not been established, reversible agranulocytosis (granulocytes <500/mm<sup>3</sup>) has been reported rarely.

### **Phlebitis**

Inflammation at the injection site has been reported.

### **Miscellaneous**

Infrequently, patients have been reported to have had anaphylaxis, drug fever, nausea, chills, eosinophilia, rashes including exfoliative dermatitis, linear IgA bullous dermatosis, Stevens-Johnson syndrome, and vasculitis in association with administration of vancomycin.

Chemical peritonitis has been reported following intraperitoneal administration of vancomycin (see PRECAUTIONS).

## OVERDOSAGE

Supportive care is advised, with maintenance of glomerular filtration. Vancomycin is poorly removed by dialysis. Hemofiltration and hemoperfusion with polysulfone resin have been reported to result in increased vancomycin clearance. The median lethal intravenous dose is 319 mg/kg in rats and 400 mg/kg in mice. To obtain up-to-date information about the treatment of overdose, a good resource is your certified Regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

## DOSAGE AND ADMINISTRATION

Sterile Vancomycin Hydrochloride, USP is intended for intravenous use only.

Sterile Vancomycin Hydrochloride, USP is not to be administered orally. An infusion rate of 10 mg/min or less is associated with fewer infusion-related events (see ADVERSE REACTIONS). Infusion related events may occur, however, at any rate or concentration.

### Patients With Normal Renal Function

#### Adults

The usual daily intravenous dose is 2 g divided either as 500 mg every 6 hours or 1 g every 12 hours. Each dose should be administered at no more than 10 mg/min or over a period of at least 60 minutes, whichever is longer. Other patient factors, such as age or obesity, may call for modification of the usual intravenous daily dose.

#### Pediatric Patients

The usual intravenous dosage of vancomycin is 10 mg/kg per dose given every 6 hours. Each dose should be administered over a period of at least 60 minutes. Close monitoring of serum concentrations of vancomycin may be warranted in these patients.

#### Neonates

In pediatric patients up to the age of 1 month, the total daily intravenous dosage may be lower. In neonates, an initial dose of 15 mg/kg is suggested, followed by 10 mg/kg every 12 hours for neonates in the 1st week of life and every 8 hours thereafter up to the age of 1 month. Each dose should be administered over 60 minutes. In premature infants, vancomycin clearance decreases as postconceptional age decreases. Therefore, longer dosing intervals may be necessary in premature infants. Close monitoring of serum concentrations of vancomycin is recommended in these patients.

### Patients With Impaired Renal Function and Elderly Patients

Dosage adjustment must be made in patients with impaired renal function. In the elderly, greater dosage reductions than expected may be necessary because of decreased renal function. Measurement of vancomycin serum concentrations can be helpful in optimizing therapy, especially in seriously ill patients with changing renal function. Vancomycin serum concentrations can be determined by use of microbiologic assay, radioimmunoassay, fluorescence polarization immunoassay, fluorescence immunoassay, or high-pressure liquid chromatography. If creatinine clearance can be measured or estimated accurately, the dosage for most patients with renal impairment can be calculated using the following table. The dosage of vancomycin per day in mg is about 15 times the glomerular filtration rate in mL/min:

**DOSAGE TABLE FOR VANCOMYCININ PATIENTS WITH IMPAIRED RENAL FUNCTION**

(Adapted from Moellering et al)<sup>3</sup>

Creatinine Clearance	Vancomycin Dose
<u>mL/min</u>	<u>mg/24 h</u>
100	1,545
90	1,390
80	1,235
70	1,080
60	925
50	770
40	620
30	465
20	310
10	155

The initial dose should be no less than 15 mg/kg, even in patients with mild to moderate renal insufficiency. The table is not valid for functionally anephric patients. For such patients, an initial dose of 15 mg/kg of body weight should be given to achieve prompt therapeutic serum concentrations. The dose required to maintain stable concentrations is 1.9 mg/kg/24 h. In patients with marked

renal impairment, it may be more convenient to give maintenance doses of 250 to 1,000 mg once every several days rather than administering the drug on a daily basis. In anuria, a dose of 1,000 mg every 7 to 10 days has been recommended. When only the serum creatinine concentration is known, the following formula (based on sex, weight, and age of the patient) may be used to calculate creatinine clearance. Calculated creatinine clearances (mL/min) are only estimates. The creatinine clearance should be measured promptly.

Men:	$\frac{\text{Weight (kg)} \times (140 - \text{age in years})}{72 \times \text{serum creatinine concentration (mg/dL)}}$
Women:	0.85 x above value

The serum creatinine must represent a steady state of renal function. Otherwise, the estimated value for creatinine clearance is not valid. Such a calculated clearance is an overestimate of actual clearance in patients with conditions: (1) characterized by decreasing renal function, such as shock, severe heart failure, or oliguria; (2) in which a normal relationship between muscle mass and total body weight is not present, such as obese patients or those with liver disease, edema, or ascites; and (3) accompanied by debilitation, malnutrition, or inactivity. The safety and efficacy of vancomycin administration by the intrathecal (intralumbar or intraventricular) routes have not been established.

Intermittent infusion is the recommended method of administration.

### Preparation and Stability

At the time of use, reconstitute vials of Sterile Vancomycin Hydrochloride with Sterile Water for Injection to a concentration of 50 mg of vancomycin/mL. (See following table for volume of diluent.)

Concentration/Vial	Volume of Diluent
500 mg	10 mL
1 g	20 mL

After reconstitution, the vials may be stored in a refrigerator for 96 hours without significant loss of potency.

Reconstituted solutions of vancomycin (500 mg/10 mL) must be further diluted in at least 100 mL of a suitable infusion solution. For doses of 1 gram (20 mL), at least 200 mL of solution must be used. The desired dose diluted in this manner should be administered by intermittent IV infusion over a period of at least 60 minutes.

### Compatibility with Other Drugs and IV Fluids

The following diluents are physically and chemically compatible (with 4 g/L vancomycin hydrochloride):

5% Dextrose Injection, USP

5% Dextrose Injection and 0.9% Sodium

Chloride Injection, USP

Lactated Ringer's Injection, USP

5% Dextrose and Lactated Ringer's Injection

Normosol®-M and 5% Dextrose

0.9% Sodium Chloride Injection, USP

Isolyte® E

Good professional practice suggests that compounded admixtures should be administered as soon after preparation as is feasible.

Vancomycin solution has a low pH and may cause physical instability of other compounds.

Parenteral drug products should be visually inspected for particulate matter and discoloration prior to administration, whenever solution and container permit.

**Rx only.**

### HOW SUPPLIED

#### NDC No.

10139-500-10 Sterile Vancomycin Hydrochloride, USP equivalent to 500 mg vancomycin in a 10 mL vial with purple flip-off seal; in packages of 10 ( **NDC 10139-500-11**).

10139-501-20 Sterile Vancomycin Hydrochloride, USP equivalent to 1 g vancomycin in a 20 mL vial with orange flip-off seal; in packages of 10 ( **NDC 10139-501-12**).

Prior to reconstitution, store dry powder at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature].

### ANIMAL PHARMACOLOGY

In animal studies, hypotension and bradycardia occurred in dogs receiving an intravenous infusion of vancomycin 25 mg/kg, at a concentration of 25 mg/mL and an infusion rate of 13.3 mL/min.

## REFERENCES

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2. Performance Standards for Antimicrobial Susceptibility Testing; 18th Informational Supplement, CLSI document M100-S18. Clinical and Laboratory Standards Institute. Wayne, PA. January, 2008.
3. Performance Standards for Antimicrobial Disk Susceptibility Tests; Approved Standard – 9th ed., CLSI document M2-A9. Clinical and Laboratory Standards Institute. Wayne, PA. January, 2006.
4. Moellering RC, Krogstad DJ, Greenblatt DJ: Vancomycin therapy in patients with impaired renal function: A nomogram for dosage. *Ann Inter Med* 1981;94:343.

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